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No. ___

OCTOBER TERM, 1980

SUPREME COURT OF THE UNITED STATES

ROBERT OKIN, MICHAEL GILL AND
WILLIAM MALAMUD,
Petitioners,

v.

RUBIE ROGERS, ABLE BOLDEN, BETTY BYBEL,
JAMES COLLERAN, DONNA HUNT, WILLIE WADSWORTH,
AND HAROLD WARNER,
Respondents.

PETITION FOR A WRIT OF CERTIORARI TO
THE UNITED STATES COURT OF
APPEALS FOR THE FIRST CIRCUIT

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QUESTIONS PRESENTED

1. Whether involuntarily committed mental patients have a constitutional right to refuse treatment with antipsychotic medication?

2. Whether the principles of federalism were violated when the United States Court of Appeals for the First Circuit remanded this case to the trial court to design creative procedural mechanisms for implementing a right to refuse treatment rather than allowing the state official defendants (who were found to have acted in good faith, in accordance with acceptable medical practice and not to have violated "clearly established constitutional rights") to develop their own procedures?

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The opinion of the Court of Appeals, not yet reported, appears in the Appendix hereto. The opinion of the District Court for the District of Massachusetts is reported at 478 F.Supp. 1342 (D. Mass. 1979) and appears in the Appendix hereto.

JURISDICTION

The judgment of the Court of Appeals for the First Circuit was entered on November 25, 1980. This petition for certiorari was filed within 90 days of that date. This Court's jurisdiction is invoked under 28 U.S.C. § 2101(c).

CONSTITUTIONAL PROVISIONS, STATUTORY PROVISIONS AND REGULATIONS

United States Constitution, Amendment Nine

United States Constitution, Amendment Fourteen, Section 1

Massachusetts General Laws c. 123, § 1

Massachusetts General Laws c. 123, § 4

Massachusetts General Laws c. 123, § 7

Massachusetts General Laws c. 123, § 8

Massachusetts General Laws c. 123, § 23

Massachusetts General Laws c. 123, § 25

Massachusetts Department of Mental Health Regulations, § 220.02

Massachusetts Department of Mental Health Regulations, § 223.03

STATEMENT OF THE CASE

On April 30, 1975, seven mental patients filed a complaint in the United States District Court, District of Massachusetts, seeking a permanent injunction and temporary restraining order ("TRO") enjoining the petitioners from forcibly confining in seclusion or medicating the patients and all other in-patients of the Austin and May Units, located at Boston State Hospital, without their consent or the consent of their guardians except where there was a serious threat of or as a result of, extreme violence, personal injury or attempted suicide. Jurisdiction was invoked under 42 U.S.C. § 1983. On April 30, 1975, the trial court issued the temporary restraining order sought by plaintiffs.

Despite attempts by the petitioners to hold a hearing forthwith on plaintiffs' motion for a preliminary injunction and to dissolve the TRO, the TRO remained in effect until the issuance of a permanent injunction by the trial court on October 29, 1979.

On December 8, 1977, the trial of the case began in the District Court. The trial combined both the injunctive issues discussed in this petition and twenty-eight malpractice and civil rights cases brought against individual doctors. Seventy-two days of testimony were taken and the evidentiary portion of the trial concluded on January 31, 1979.

On October 29, 1979, the District Court issued an order and judgment which stated, in relevant part "that the defendants, their agents and employees, are restrained from forcibly . . . medicating the plaintiffs and all other inpatients of the Austin and May Units, and successor units, of the Boston State Hospital without the patient's consent or the consent of the patient's guardian, if any, except where there is a substantial likelihood of, or as a result of, extreme violence, personal injury or attempted suicide." Appendix, pp. 162a-163a. The trial court also found that the defendants acted in good faith, in accordance with standards of reasonable medical practice, and did not violate any clearly established constitutional rights. Appendix, pp. 139a, 140a, 149a, 150a. Accordingly, the trial court denied all damage claims against the defendants.

The trial court's permanent injunction, as well as its temporary restraining order, required a change in medication practices at the Austin and May Units from those practices which existed before court intervention. First Circuit Appendix pp. 356-357, 293-304 (J-321-328, J-86-92). Moreover, the court's orders prohibited what was standard medical practice before the court's intervention. First Circuit App. pp. 308-311 (J-108-123). The trial court's order limited the forcible use

of therapeutic medication to the same situations justifying the use of restraints such as seclusion. Before the trial court's orders, patients at times were forcibly medicated in psychiatric emergencies, although their conditions would not have justified the use of seclusion and did not constitute a serious threat of personal injury to themselves or others. First Circuit App. p. 302 (J-88). In circumstances not presenting an immediate physical threat to the patient or others, the court's order prohibited the use of forcible medication even (1) when it was a necessary treatment to alleviate severe psychic suffering or acute psychosis, and (2) even when it was necessary to prevent a patient from deteriorating to a point where he may later present a serious physical threat to himself or others. First Circuit App. pp. 346-348, 352-354 (J-282-290, 308-316). The court's opinion required use of the cumbersome guardianship process even when the patient continued to suffer pending the delays inherent in the court procedure.

Defendants Okin (Commissioner of the Massachusetts Department of Mental Health), Malamud (inpatient director of the Solomon Carter Fuller Mental Health Center, which is the May Unit's successor unit), and Gill (former inpatient director of the Johnson Unit of the Tufts-Bay Cove Mental Health Center, which is the

Austin Unit's successor unit) noticed their appeal to the United States Court of Appeals for the First Circuit on November 19, 1979, from that part of the Court's order enjoining the forcible use of antipsychotic medication. On November 25, 1980, the First Circuit issued its opinion.

The First Circuit affirmed the trial court's denial of damages. The First Circuit agreed that the record supported the trial court's findings that (1) defendants had acted in subjective good faith, (2) defendants had not violated "clearly established" constitutional rights, and (3) defendants had not acted negligently. Appendix, pp. 32a-33a, 37a.

The First Circuit also agreed with the trial court's ruling that antipsychotic medication cannot be forcibly administered to involuntarily committed mental patients solely for treatment purposes absent an additional judicial finding of incompetency. Appendix, p. 14a. On the other hand, the First Circuit apparently broadened the trial court's definition of emergency, declaring that patients could be forcibly medicated without a declaration of incompetency (1) where a doctor belives in his professional judgment that the medication is necessary to prevent potential violence, pp. 7a-15a, and (2) where any delay could result in significant deterioration of the patient's mental health. Appendix, pp. 24a-26a.

The First Circuit specifically declared:

Defendants' second basic complaint is that the necessity of finding a "substantial likelihood of physical harm . . ." (See note 3, supra) is an overly rigid and unworkable requirement.

* * *

[I]t does appear that the district court may have overlooked or misconstrued evidence of specific acts of violence occurring as a result of defendants' difficulty in applying the court's standard.

* * *

The professional judgment-call required in balancing these varying interests and determining whether a patient should be subjected to forcible administering of antipsychotic drugs demands an individualized estimation of the possibility and type of violence, the likely effects of particular drugs on a particular individual, and an appraisal of alternative, less restrictive courses of action.

* * *

> Not only do we deem out of place a simplistic unitary standard for police power emergency drug administration, but we see particular problems in adopting such a standard that can be interpreted as requiring a prediction of more-probable-than-not violent behavior.

Appendix, pp. 8a, 9a, 11a, 12a.

Moreover, while the trial court's order forbid forcible medication in a non-emergency without the consent of the patient's guardian, the First Circuit stated:

> . . . [A]s a constitutional matter, the state is not required to seek individualized guardian approval for decisions to treat incompetent patients with antipsychotic drugs.

Appendix, p. 30a.

The First Circuit issued an order declaring:

> Judgment affirmed in part, reversed in part, and vacated and remanded for further proceedings in accordance with this opinion.

Appendix, p. 39a.

The First Circuit remanded the case to the trial court with instructions "to be creative in designing procedural mechanisms" to enforce a mental patient's right to refuse treatment. Appendix, pp. 14a-15a.

Despite the apparent contradictions between the First Circuit's opinion and the trial court's opinion and despite the First Circuit's order vacating the judgment, the trial court declared on remand on December 18, 1980 that as far as the trial court was concerned, its order stands and was not vacated. Appendix, pp. 176a-178a. The trial court indicated that in its opinion only its order regarding voluntary patients had been reversed. On December 22, 1980, the petitioners filed with the First Circuit a motion to clarify its order in light of the trial court's statements on December 18, 1980. On January 28, 1981, the First Circuit declined to clarify its opinion. Appendix, pp. 164a-165a.

ARGUMENT

I. AN INVOLUNTARILY COMMITTED MENTAL PATIENT'S CONSTITUTIONAL RIGHT TO REFUSE TREATMENT RAISES IMPORTANT QUESTIONS WHICH SHOULD BE DECIDED BY THIS COURT.

A. General Importance of This Case

1. At issue in this case is the ability of state hospitals to administer essential treatment to its involuntarily committed mental patients. As the First Circuit found in this case, "[t]oday . . . due in large part to the development of numerous drugs for treating mental illness, the possibility of improvement as a result of forced treatment is relatively substantial." Appendix at p. 17a. Testimony of two of the leading psychopharmacologists in the country indicated that for major mental illness, psychotropic drugs are a central component of any treatment program. First Circuit Appendix, p. 320 (J-152). Dr. Henry Brill, former President of the American College of Neuropharmacology, testified that after reading thousands of articles on the subject, he has concluded that there are no articles which show there is not a general consensus as to the relative safety and effectiveness of antipsychotic medication, and, to his knowledge, there has never been a well designed study showing that antipsychotic drugs are not relatively safe and effective. First Circuit Appendix, p. 321 (J-161-162).

2. At issue in this case is whether the state has an obligation to treat those persons whose freedom it has taken away because of mental illness. No person in Massachusetts can be committed solely because they are dangerous. Rather, they must have been found to be mentally ill. The state has an obligation to seek to restore to freedom those persons whose freedom has been taken away because of their sickness.

3. At issue in this case is the state's obligation to prevent the needless suffering from mental illness of those individuals so sick as to have been committed.

4. At issue in this case is the role of the state hospital in society. Patients are committed to state hospitals until they are treated. If the hospitals are then denied the power to treat the patient over his objections, our state hospitals will become, in fact, if not in name, caretaking facilities, more akin to correctional institutions than hospitals. Patients, who are not treated, are warehoused.

5. At issue in this case is the ability to attract doctors and staff to work in state hospitals. Restricting forcible medication mandates doctors to treat patients in a contrary fashion to what they believe to be proper practice. To deny doctors the use of psychotropic medication is to return them to the wards of the early 1950's, when the only treatments available for persons suffering from major psychosis were seclusion rooms,

shock therapy, hot baths, wet sheets, straight jackets and lobotomies. It is unreasonable to expect dedicated doctors and staff, already underpaid and working with the sickest and most dangerous of mental patients, to continue to work at state hospitals under these conditions.

6. At issue in this case is the ability of states to continue reducing state hospital populations. Before the introduction of antipsychotic drugs, there never had been a time in the history of mental hospitals, which goes back for some 200 years, when there had been a reduction of population, despite efforts to do away with the hospitals, to close the hospitals, or to reduce their populations. First Circuit App., p. 334 (J-218). However, when antipsychotic drugs were introduced, the increase of population stopped, the behavior in the hospitals improved and subsequently there has been a decrease of mental hospital population of rather spectacular proportions. First Circuit App., pp. 334-335 (J-219-222). Because of antipsychotic medication, community programs are now possible for many patients who previously required hospitalization. First Circuit App., p. 335 (J-225). Furthermore, the widespread use of pharmacotherapeutic agents has also reduced the duration of hospitalization for patients at mental hospitals to a fraction of the previous duration. First Circuit App., p. 335 (J-223).

7. At issue in this case is whether cumbersome judicial procedures must be followed to make treatment decisions for involuntarily committed patients. The First Circuit would require a judicial declaration of incompetency before an involuntarily committed patient can be forcibly treated in a non-emergency. The trial court order still in effect requires the consent of a guardian before a patient can be forcibly medicated. Guardianship hearings can result in temporary or permanent deprivation of needed attention, loss of a patient's remaining legal rights, the patient's escape pending the hearing, and the creation of an adversarial relationship with the doctor petitioning for the declaration of incompetency.

8. At issue in this case is the state's ability to protect patients and staff from preventable violence. Under the trial court order still in effect a patient cannot be forcibly medicated unless there is a substantial likelihood of violence. All acutely psychotic psychotic patients (i.e., those patients at state hospitals) have the potential for impulsively committing a dangerous act. Anderson and Kuehnle, "Strategies for the Treatment of Acute Psychosis", Journal of the American Medical Association, September 30, 1974, at 1884-1886. (J-299-302). Given this potential for impulsive violence,

the failure to medicate a patient forcibly increases the chances of such an impulsive act being committed. This potential for violence is particularly disturbing given the evidence in both this case, First Cir. App., p. 342 (J-262) and in Rennie v. Klein, 462 F.Supp. 1131, 1152, n. 1 (D.N.J. 1978) that one patient refusing medication frequently sets off a contagion of refusal.

9. At issue in this case is whether the law should prevent potential abuses of forced medication not found in the record below or whether it should permit state hospitals to function effectively on a day-to-day basis. See Parham v. J.R., 442 U.S. 584, 612 (1979)("That there may be risks of error in the process affords no rational predicate for holding unconstitutional an entire statutory and administrative scheme that is generally followed in more than 30 states.") Psychotic patients, by definition, are not rational. If a person not in need of treatment is wrongly treated in a hospital, the remedy is through an individual action, challenging the propriety of the treatment or hospitalization, and, if appropriate, seeking monetary damages. O'Connor v. Donaldson, 422 U.S. 563 (1975). The remedy is not to grant the vast majority of irrational people in need of treatment the right to refuse that treatment.

B. Important Problems With The First Circuit Opinion

1. There Is No Constitutional Foundation for the Creation of A Right to Refuse Treatment for Involuntarily Committed Mental Patients

The First Circuit declared that it was "intuitively obvious" that a person has a constitutionally protected interest in being left free to refuse antipsychotic medication, although "[t]he precise textual source of this interest is unclear". App, p. 4a. The First Circuit wrote that the source of the right was "most likely" a part of the penumbral right to privacy, bodily integrity or personal security. App., p. 5a.

The First Circuit further incorrectly asserted that none of the parties contest the correctness of the above general proposition. App. p. 6a.

In fact, it is not surprising that the First Circuit had such difficulty in identifying a specific constitutional source for a right to refuse treatment, because there is no precedent of this Court supporting such a right.

Roe v. Wade, 410 U.S. 113 (1973), remains the most thorough and authoritative exposition by this Court of that fundamental, constitutional right of privacy later

characterized as "the interest in independence in making certain kinds of important decisions." Whalen v. Roe, 429 U.S. 589, 599-600 (1976). The Court in Roe v. Wade held that "only personal rights that can be deemed 'fundamental' or 'implicit in the concept of ordered liberty' . . . are included in this guarantee of personal privacy." 410 U.S. at 152 (citations omitted).

The decisions surveyed in Roe v. Wade, 410 U.S. at 152-153, along with privacy decisions by this Court since 1973, make clear that the constitutional right of privacy clusters closely around the related concepts of marriage, family and procreation. In the Handbook of Free Speech and Free Press at 369 (1979), Professors Barron and Dienes note that this Court has not indicated that the constitutional privacy right should be interpreted broadly to protect all facets of the "right to be let alone".

The right of involuntarily committed mental patients to refuse treatment is plainly not of the same order or type as the interests accorded protection by previous decisions of this Court. The fact that the patients involved in this case are all institutionalized is of primary importance. By definition, an institutionalized person under the care and supervision of the state no longer enjoys the privacy of a person living in his own

home; what would be private decisions for a person living in his own home are inexplicably intertwined for the institutionalized person with the interests of the state and other patients.

As the right to privacy involved in this case is not the fundamental constitutional right to make certain personal decisions, the patients' right to privacy claim must rest on a right to be free from bodily intrusion by the government. However, as this Court noted in Jacobson v. Massachusetts, 197 U.S. 11, 31 (1904), the proper role for the judiciary in analyzing state impositions upon bodily integrity is not to examine the efficacy of the state's methods but only to inquire whether or not those methods bear a "real and substantial relation" to legitimate state objectives. The Jacobson Court thus applied the classic "rational relation" test, concluding, in effect, that the minimal intrusion into bodily integrity which these injections entailed warranted only minimal judicial scrutiny. Only in radically more extreme cases, where the state's power was "exerted in such circumstances" as to be "arbitrary and oppressive" could any stricter form of scrutiny be invoked. 197 U.S. at 38.

In more recent Fourth and Fourteenth Amendment cases, the Supreme Court has held that bodily intrusions

will be upheld if they are not "brutal", "offensive" or "shock the conscience". Rochin v. California, 342 U.S. 165, 172 (1952); Breithaupt v. Abram, 352 U.S. 432, 435 (1956); Schmerber v. California, 384 U.S. 757, 768 (1966). To apply strict judicial scrutiny to unconsented touchings which do not reach the threshold level of intrusiveness, outlined in Rochin, Breithaupt and Schmerber, would be to elevate what is at most a technical tort to the highest level of constitutional protection.

The First Circuit, having failed to analyze the exact nature of the "privacy" interests involved in this case, "intuitively" decided that a fundamental constitutional right was involved in this case. Thus, the First Circuit never asked the proper question of whether forcible medication is "brutal", "shocks the conscience" or is rationally related to a legitimate state objective. Rather, they improperly put the Commonwealth to prove that its interests outweighed the interests of the patients in refusing medication. App., p. 15a.

2. Involuntarily Committed Patients Do Not Have A Constitutional Right to be Treated in the Least Restrictive Manner

The First Circuit found that implicit in the right to refuse antipsychotic medication is an obligation on the

state to use less restrictive alternatives than forced medication when available. However, in Sanchez v. New Mexico, 396 U.S. 276 (1970), this Court dismissed, for want of a substantial federal question, an appeal taken from the New Mexico Supreme Court's decision in State v. Sanchez, 80 N.M. 438, 457 P.2d 370 (1960). The New Mexico Court had held, in a challenge to that state's civil commitment statute, that "the policy which [plaintiff's] counsel denominated as that of 'Least Abridgment' has no application to the case before us." Thus, if the doctrine of least restrictive alternatives has no application to the initial deprivation of liberty, a fortiori it cannot apply to individual treatment decisions made after commitment.

Moreover, as applied by this Court, the least restrictive means test has never been more than an adjunct to judicial strict scrutiny, employed to ensure a precise means-end fit when legislation encroached upon fundamental rights. See Sheldon v. Tucker, 364 U.S. 479, 498 (1960). Although "particularly important to the free speech area," the test has occasionally "been applied in non-speech areas, such as state regulation affecting interstate commerce." J. Nowak, R. Rotunda, J. Young, Handbook on Constitutional Law (1978) at 727. But even when cast loose from its first amendment roots, the function of the least restrictive alternative test has

remained constant: it is a mode of inquiry into the constitutionality of legislation, and not into the propriety of individual acts.

Finally, to subject every decision to medicate a patient to the least restrictive means test would harm patients by forcing physicians to concentrate on the wrong questions. Rather than asking, in each instance, what treatment would most benefit the individual patient, the doctor would have to ask himself what treatment would be viewed by a judge as the least restrictive appropriate treatment. Such deliberations would inevitably militate in favor of the least possible treatment, short of total neglect.

3. The Commonwealth's Right to Treat Involuntarily Committed Patients Should Not Be Tied to A Judicial Determination of Incompetency

The First Circuit found that given the patient's constitutional right to refuse treatment, in order for the state to invoke its parens patriae interest as a justification to treat an involuntarily committed patient, in a non-emergency it must first obtain a judicial determination that the patient is incompetent. The First Circuit then concluded that under Massachusetts law there is no determination of incompetency at the time of

commitment. The First Circuit failed to explain why incompetency (rather than the taking away of a person's freedom through commitment) is the sole factor relevant to whether a state can exercise its parens patriae powers.

In fact, a determination of incompetency is particularly inappropriate as the trigger to justify forcibly medicating a patient. Competency to determine one's need for psychiatric treatment can vary on a day-to-day basis. First Cir. App., p. 402 (J-383, 384). In other words, a patient's symptoms frequently vary on a day-to-day basis affecting their competency. Thus, it makes no sense to have to seek a judicial declaration of incompetency to forcibly medicate a patient, when the same patient found judicially incompetent may act competently the day after the court determination.

The constant factor for a committed patient is his mental illness. In Massachusetts, when a patient is no longer in need of care for his mental illness, he must be released from the hospital. Mass. Gen. Laws c. 123, § 4. Whether or not the patient is competent on any given day is irrelevant to whether the patient can be committed or released and should be irrelevant to whether the patient can be treated.

The court below failed to explain why the fact that involuntary patients have been found to be mentally ill is

not justification for forcibly treating them. In fact, involuntarily committed patients are considered so mentally ill that society has decided to override their failure to seek hospitalization voluntarily and their implicit, if not explicit, objection to being hospitalized for treatment. Given that these patients have already been recognized as so mentally ill that their decision to reject voluntary hospitalization and its treatment has been overridden, it is illogical to accept the patient's same objections to treatment once hospitalized.

The First Circuit quotes the following language from an article entitled "Developments in the Law — Civil Commitment of the Mentally Ill", 87 Harvard L. Rev. 1190, 1344 (1974):

> "Inherent in an adjudication that an individual should be committed under the state's parens patriae power is the decision that he can be forced to accept the treatments found to be in his best interest; it would be incongruous if an individual who lacks the capacity to make a treatment decision could frustrate the very justification for the state's action by refusing such treatments."

App., pp. 16a-17a. It is difficult to understand how the First Circuit interprets this language to do

anything but contradict its own conclusion that the fact of commitment is insufficient justification for forcible treatment.

4. The First Circuit's Definition of an Emergency Situation Justifying Forcible Medication Is Too Narrow

The First Circuit recognized that patients could be forcibly medicated where a doctor believed the medication was necessary to prevent violence and where any delay could result in significant deterioration of the patient's mental health. App., pp. 7a-15a, 24a-26a. It is a mistake to limit the definition of emergency in a psychiatric hospital to these two situations.

Dr. Shervert Frazier, chief psychiatrist at McLean Hospital and former Commissioner of the Texas Department of Mental Health, examined the results of a survey conducted by the American Psychiatric Association and the National Institute of Mental Health to determine different definitions of psychiatric emergencies employed by hospitals. Frazier, "Comprehensive Management of Psychiatric Emergencies", 9 Psychosomatics 7 (1968). Of the 89 definitions received, Frazier concluded that only three appeared to have been carefully thought through. Specifically, Frazier suggested adopting the definition

that a psychiatric emergency is any urgent psychiatric condition, functional or organic, for which immediate treatment would increase or contribute to the patient's likelihood of recovery, or provide urgently needed protection. First Circuit App., p. 306 (J-100). Petitioners suggested that a psychiatric emergency might also be defined as a situation when a patient requires the prompt initiation of medication treatment to prevent further severe suffering by that patient or the rapid worsening of that patient's clinical state. The First Circuit apparently adopted one-half of petitioner's definition, but failed to recognize the need to prevent severe suffering as a reason for forcibly medicating a patient regardless of the patient's competency.

Psychotic patients, whether or not dangerous or incompetent, frequently experience intense suffering. are terrorized by their illness and are in a state of internal panic, unbearable agony, pain and distress. First Cir. App., pp. 347-348 (J-288). The panic may manifest itself in various physical signs, such as a great deal of hyper-ventilation, clenching of fists, rapid breathing, rapid pulse, pained facial expressions, or a terrorized look in the eyes. Id. At least three doctors at trial testified that to be psychotic is to suffer severely. First Cir. App., p. 347 (J-285-287). Thus, the failure to forcibly

medicate patients who are acutely psychotic, even if they are not in danger of significantly deteriorating, creates unnecessary pain and panic for the patients. First Cir. App., pp. 346-347 (J-283, 284). The First Circuit failed to explain why the Constitution requires this "pain and panic" for a "competent" person so mentally ill as to be committed or an "incompetent" committed person pending a competency hearing.

5. The First Circuit's Opinion Has Been Interpreted By the Trial Court As Failing to Vacate Its Original Order

The trial court has interpreted the First Circuit's opinion as upholding its original order. App., pp. 176a-178a. The permanent injunction in this case was virtually identical to the temporary restraining order issued in this case on April 30, 1975 and remaining in effect through the conclusion of the trial approximately three and one-half years later. The history of the hospitals having to honor a patient's "right to refuse treatment" supports the Commonwealth's contention that there is even a compelling state interest in forcibly medicating patients.

The temporary restraining order had a deleterious effect upon patient care, creating increased tension and situations that were extremely difficult and dangerous.

First Cir. App., pp. 355-356 (J-319-320). See, generally, First Cir. App., pp. 355-373 (J-319-377).

After the temporary restraining order, many patients refused their medication. First Cir. App., pp. 357-358 (J-329-332). On any given day, approximately 10 to 12 patients would refuse medication. First Cir. App., p. 357 (J-330). There were a core of patients who refused medication for prolonged periods. First Cir. App., p. 358 (J-332).

The inability to medicate forcibly acutely psychotic patients not constituting serious threats of violence at the time resulted in acts of violence down the road by some of these patients refusing medication. First Cir. App., pp. 358-360 (J-333-360).

Other patients refusing medication were denied inpatient care because the temporary restraining order prevented staff from providing adequate treatment which necessarily would have included the use of medication. First Cir. App., pp. 360-361 (J-339-341). There were a number of patients, however, refusing treatment, who had to be "warehoused", as the expectation of their survival in the community was so low it precluded release from the protective custody of the hospital. First Cir. App., p. 361 (J-340).

A number of patients after the temporary restraining order found themselves caught in a vicious circle. They refused medication until they deteriorated to a point where they were forcibly medicated only to improve enough from the medication to require that its forcible administration be stopped, again causing their deterioration. First Cir. App., pp. 361-363 (J-342-345).

The temporary restraining order resulted in increased lengths of stay and prolonged unnecessary psychic suffering for some patients. First Cir. App., pp. 363-368 (J-346-355). Patients, many of whom were awaiting guardianship hearings, remained acutely psychotic for months without receiving medication. First Cir. App., pp. 363-364 (J347).

The temporary restraining order negatively affected ward milieu and interfered with treatment relationships between patients and staff. First Circ. App., pp. 368-370 (J-356-366). There was an atmosphere of violence on the wards which did not exist before. First Cir. App., pp. 368-369 (J-357). Moreover, the restraining order created an adversarial situation between patients and staff. First Cir. App., p. 369 (J-358-359). Patients tested the staffs' commitment to helping by refusing medication, and in their own diseased minds, found that commitment wanting

when staff could not take firm measures. First Cir. App., pp. 369-370 (J-360-365).

Following the temporary restraining order, there was an increase in the number of patients who needed to be transferred to Bridgewater State Hospital, a maximum security facility. First Cir. App., pp. 371-372 (J-367-370). Transfers to Bridgewater from the May Unit were three to four times greater than before the temporary restraining order, while transfers from the Austin Unit were five to six times greater than before the temporary restraining order. First Cir. App., p. 371 (J-367, 369).

Finally, the temporary restraining order had a negative effect on the staffing of the Austin and May Units. First Cir. App., pp. 372-373 (J-371-375). Staff turnover at the Austin Unit approximately doubled after the restraining order. First Cir. App., p. 372 (J-371). The issuance of the restraining order contributed to the loss of the psychiatric residency program at the May Unit's successor unit, when it was concluded that the inpatient service was too dangerous for a single resident to be assigned to a ward. First Cir. App., p. 373 (J-375). Some staff left, unable to watch patients deteriorate or suffer

who could have been treated with medication. First Cir. App., p. 372 (J-373). It is a sad commentary that of the fourteen defendants in this case, all well-educated and trained and working at state hospitals during the period covered by the suit, only two continue to work at a state hospital today. First Cir. App., pp. 1871-1880 (B-8-21).

It is of considerable significance that while the Commonwealth presented much evidence of the negative effects of the temporary restraining order, the patients did not present any evidence whatsoever of anyone who benefitted from the order during the three and one-half years it was in effect. Nor did the patients even call a single witness to testify who disagreed with the Commonwealth's appraisal of the disastrous effects of the court's order.

Alan Stone, professor at Harvard Law School and former President of the American Psychiatric Association, commenting on the Rogers case, sums up, by stating:

> This scenario [at the Austin and May Units after the temporary restraining order] has developed despite the fact that the patient census in this hospital is very small by state

hospital standards and the staff is far above average in quality. Clearly, an unqualified right to refuse medication would result in serious harm to both patients and staff at this and other hospitals, in which those confined are increasingly selected for their dangerousness rather than their medical condition. As one reads this description, [of the Units] one can only conclude that the courts are unwittingly reversing 200 years of progress and transforming the twentieth century dream of the mental health center into the eighteenth century nightmare of Bedlam. "Recent Mental Health Litigation: A Critical Perspective," 134 Am. J. of Psych., 273, 278 (1977).

II. THIS COURT SHOULD ISSUE A WRIT OF CERTIORARI AS THERE IS A CONFLICT IN THE COURTS REGARDING A PATIENT'S RIGHT TO REFUSE ANTIPSYCHOTIC MEDICATION.

The First Circuit opinion directly conflicts with the Minnesota Supreme Court's rulings in the cases of Price v. Shepard, 307 Minn. 250, 239 N.W. 2d 905 (1976) and In the Matter of the Alleged Mental Illness of Paul Fussa, (Docket No. 469, Minn.S.Ct., June 14, 1976). In Price the court asked "whether the state, consistent with [the plaintiff's] right of privacy, can assume the decision of whether [plaintiff], an involuntarily committed mental patient, will undergo psychiatric treatment." 239 N.W. 2d at 911. The case involved electroshock therapy, certainly radically more intrusive than the drug therapy under consideration in this case. The court concluded:

> We observe that the more fundamental decision, whether he was to undergo hospitalization, was assumed by the state at the commitment proceeding, the validity of which is not contested.
>
> . . . Under the circumstances of this case [the state's] interest can be articulated as the need for the state to assume the decision-making role regarding psychiatric treatment for

> one who, presumptively, based on the fact of commitment on the basis of mental illness,[1] is unable to rationally do so for himself. If that interest of the state is sufficiently important to deprive an individual of his physicial liberty, it would seem to follow that it would be sufficiently important for the state to assume the treatment decision. We hold that it is.
>
> 239 N.W. 2d at 911.

Although the Price court went on to condition the non-consenual imposition of extraordinarily intrusive treatments such as electroshock therapy and psychosurgery upon additional procedural safeguards, the same court later declined to upset a lower Minnesota court holding that these additional procedures were not required for the involuntary administration of psychotropic drugs. In the Matter of the Alleged Mental Illness of Paul Fussa, supra.

1/ The Court recognized that while commitment is not the equivalent of an adjudication of mental incompetency, it nevertheless reflects a judicial determination that the individual lacks the capacity to make his own decision regarding hospitalization. 239 N.W. 2d St. 911, n. 7. The court also recognized the incongruity of allowing a patient who is thus incapacitated to refuse the treatment which was the justification for this commitment.

A potential conflict[2/] also exists between the First Circuit's opinion and the Third Circuit's awaited opinion in Rennie v. Klein, Docket Nos. 79-3576, 2577. (The trial court opinions in Rennie are reported at 462 F.Supp. 1131 (D.N.J. 1978) and 476 F.Supp. 1294 (D.N.J. 1979).[3/] The Third Circuit recently decided on January 5, 1981, to rehear Rennie en banc.

2/ See Gulf States Steel Co. v. United States, 287 U.S. 32 (1932) for an example of this Court granting certiorari where a potential conflict existed between a district court opinion pending on appeal and the opinion of the court of appeals reviewed by this Court.

3/ There are at least three other recently decided cases discussing an involuntarily committed mental patient's right to refuse treatment. Davis v. Hubbard, 49 U.S.L.W. 2215 (U.S.D.C.N. Ohio, September 30, 1980); In re K.K.B., 609 P.2d 747 (Oklahoma 1980); Goedecke v. State Department of Institutions, __ Colo. __, 603 P.2d 123 (1979). While all three cases found a constitutional right to refuse treatment, they differed in their opinions regarding the foundation of this "right", and Davis differed as to the required procedures accompanying this "right". While probably none of these cases act as a conflicting opinion justifying the granting of certiorari, see U.S. Supreme Court Rule 17(a), the number of other courts deciding the issue of a "right to refuse treatment" acts as evidence of the importance of the issues raised. See Calhoun v. Harvey, 379 U.S. 134, 137 (1964); Curtis v. Loether, 415 U.S. 189, 191, n.2 (1974); Beal v. Doe, 432 U.S. 438, 443, n. 7 (1977).

III. THE FEDERALISM ISSUES IN THIS CASE ARE IMPORTANT AND SHOULD BE SETTLED BY THIS COURT.

The First Circuit found that the record supported the trial court's findings that (1) defendants had acted in subjective good faith, (2) defendants had not violated clearly established constitutional rights, and (3) defendants had not acted negligently. App., pp. 32a-33a, 37a. Yet, despite these findings of no deliberately wrongful or even negligent behavior, the First Circuit has not left to the defendants the power to promulgate their own regulations consistent with the substantive law as declared in the First Circuit opinion.

The First Circuit noted only two constitutional procedural requirements for forcibly medicating patients; they described these constitutional requirements as minimum requirements of due process.[4/] Nevertheless,

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4/ The First Circuit established the following minimum requirements of due process: (1) the determination that medication is necessary must be made by a qualified physician as to each individual patient to be medicated, App., p. 14a; (2) there might be some mechanism for periodic review by non-treating physicians of the full treatment history of patients treated under the parens patriae power to ensure that the treating physicians are in fact attempting to make treatment decisions as the patients themselves would were they competent. App. p. 29a.

the First Circuit remanded the case to the trial court with instructions "to be creative in designing procedural mechanisms" which apparently will exceed these minimum constitutional requirements. App. pp. 14a-15a. In light of the remand to design procedures, the state officials in this case find themselves faced with ongoing federal supervision of their actions and the need to go to court to make any changes in the procedures ordered by the trial court. This loss of flexibility has been imposed on the state officials despite the lack of a finding of any active wrongdoing on their part in the past. See, Parham v. J.R., 442 U.S. 584, 615-616 (1979) where this Court noted the relevance of defendants having acted in good faith in declaring that no new procedures need be ordered by the Court.

As this Court noted in Rizzo v. Goode, 423 U.S. 362, 378 (1976), the considerations of federalism dictating against federal courts fashioning prophylactic procedures for state agencies raise important issues. In Rizzo, this Court declared:

> '[T]he nature of the violation determines the scope of the remedy'
>
> * * *
>
> Where, as here, the exercise of authority by state officials is attacked, federal courts must

> be constantly mindful of the 'special delicacy of the adjustment to be preserved between federal equitable power and state administration of its own laws.'
>
> * * *
>
> When a plaintiff seeks to enjoin the activity of a government agency, even within a unitary court system, his case must contend with 'the well-established rule that the Government has traditionally been granted the widest latitude in the 'dispatch of its own internal affairs,'
>
> * * *
>
> When the frame of reference moves from a unitary court system, governed by the principles just stated, to a system of federal courts representing the Nation, subsisting side by side with 50 state judicial, legislative, and executive branches, appropriate consideration must be given to principles of federalism in determining the availability and scope of equitable relief.

423 U.S. at 378, 379 (Citations omitted).

The First Circuit, in remanding this case, has ignored the dictates of Rizzo. Significantly, in Rizzo,

this Court found the principles of federalism to be violated despite the fact that the district court's remedy was one that the police department defendants could live with.[5/] 423 U.S. at 381 (Blackmun, J., dissenting).

The First Circuit's remand equally disregards the mandate of this Court set forth in Bell v. Wolfish, 441 U.S. 520, 561 (1979):

> The deplorable conditions and draconian restrictions of some of our Nation's prisons are too well known to require recounting here, and the federal courts rightly have condemned these sordid aspects of our prison systems. But

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5/ Thus, there is no need in this case to wait to grant certiorari until it is determined whether petitioners can live with the trial court's procedures. At issue is the correctness of the remand itself, and whether the petitioners are to lose their authority to create their own procedures. Moreover, the "right to refuse" treatment issue is ripe for review. The trial of the issue is complete and no additional evidence will be presented on remand. Moreover, a determination of whether a patient has a "right to refuse treatment" is fundamental to a determination of whether there are any procedures constitutionally required. Finally, petitioners, having lived under the temporary restraining order and permanent injunction in this case for close to six years should not be required to wait any longer for a final resolution of this issue.

> many of these same courts have, in the name of the Constitution, become increasingly enmeshed in the minutiae of prison operations. Judges, after all, are human. They, no less than others in our society, have a natural tendency to believe that their individual solutions to often intractable problems are better and more workable than those of the persons who are actually charged with and trained in the running of the particular institution under examination. But under the Constitution, the first question to be answered is not whose plan is best, but in what branch of the Government is lodged the authority to initially devise the plan.

Finally, the First Circuit should have, but did not, follow the lead of this Court in Parham v. J.R., 442 U.S. 584, 607-608 (1979), where this Court refused "to outline with specificity" what medical investigative techniques must be followed given the already established existence of traditional medical investigatory techniques.

CONCLUSION

For the reasons stated in this Petition, a writ of certiorari should issue to review the judgment and opinion of the First Circuit.

Respectfully submitted,

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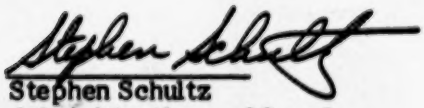
ATTORNEY GENERAL



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